UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 7 OF 14

Preventive Care Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

To see a list of the preventive benefits and immunizations that are mandated by the Patient Protection and Affordable Care Act (PPACA), you may go to the following website: www.HealthCare.gov/center/regulations/prevention.html. You may also contact BCBSM customer service.

Most preventive care services are covered only when performed by an in-network provider. However, colonoscopies, mammograms, and women's contraceptive services that are preventive in nature are covered whether performed by an in-network or out-of-network provider. This section describes what we cover for all preventive care services.

Locations: We pay for facility and professional services for preventive care in the following locations subject to the conditions described below:

- A participating outpatient hospital or participating facility
- A professional provider's office

  We also pay for the analysis of a laboratory test when rendered by an independent laboratory.

We pay for:

We pay for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by in-network providers. However, if an in-network provider performs a covered preventive test, but an out-of-network provider reads and interprets the results, we will pay the out-of-network claim as if the service was performed by an in-network provider. This means your out-of-network deductible and out-of-network copayment will not be imposed.

Deductibles and copayments are not required for these services when performed by an in-network provider.

- Health Maintenance Examination

  One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, skin exam for malignancy, breast exam, testicular exam, rectal exam and health counseling regarding potential risk factors.

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Preventive Care Services (continued)

- Flexible Sigmoidoscopy Examination

  One routine flexible sigmoidoscopy examination per member, per calendar year.

- Gynecological Examination

  One routine gynecological examination per member, per calendar year.

- Routine Pap Smear

  Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.

- Screening Mammography

  – We pay for one routine mammogram and the related reading, once per member per calendar year to screen for breast cancer. This service is not subject to any deductible or copayment requirements when provided by in-network providers. Mammography services performed by an out-of-network provider are subject to the out-of-network deductible and copayment requirements of your certificate.

Readings and interpretations by out-of-network providers are payable only when the screening mammogram itself is performed by an in-network provider.

- Fecal Occult Blood Screening

  One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.

- Well-Baby and Child Care Visits

  We pay for well-baby and child care visits as follows:

  – Eight visits for children from birth through 12 months
  – Six visits for children 13 months through 23 months
  – Six visits for children 24 months through 35 months
  – Two visits for children 36 months through 47 months
  – Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit

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Preventive Care Services (continued)

- Immunizations

  We pay for childhood and adult immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM.

  We pay for all other immunizations and preventive care benefits mandated by PPACA at the time services are performed.

- Prostate Specific Antigen Screening

  We pay for one routine prostate specific antigen screening per member, per calendar year.

- Routine Laboratory and Radiology Services

  We pay for the following services once per member, per calendar year, when performed as routine screening:

  - Chemical profile
  - Complete blood count or any of its components
  - Urinalysis
  - Chest X-ray
  - EKG
  - Cholesterol testing

- Colonoscopy

  Hospital and physician benefits for colonoscopy services are payable at 100 percent of the BCBSM approved amount as follows:

  - We pay for one routine screening colonoscopy once per member per calendar year, whether performed by an in-network or out-of-network provider.
  - Services performed by an in-network provider are not subject to any deductible or copayment requirements.
  - Services performed by an out-of-network provider are subject to the out-of-network deductible and copayment requirements of your certificate.
  - Subsequent medically necessary colonoscopies performed during the same calendar year by an in-network or out-of-network provider are subject to your deductible and copayment requirements.

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Preventive Care Services (continued)

- Women's Preventive Care Contraceptive Services
  - Voluntary Sterilization for Females

    We pay for hospital, facility, and physician benefits for voluntary sterilizations for females. See Page 16 for your cost-sharing requirements.
  - Contraceptive Devices

    We pay for a contraceptive device requiring a prescription by a physician, certified nurse midwife, or other legally authorized professional provider and for the insertion and removal of a device by a physician. , certified nurse midwife, or other eligible provider.
  - Contraceptive Injections

    We pay for contraceptive injections given by a physician, certified nurse midwife, or other legally authorized professional provider, including the cost of the medication when provided by the physician, nurse midwife or other eligible provider. Contraceptive medication you obtain from the pharmacy is not covered. When the physician, certified nurse midwife, or other legally authorized professional provider injects contraceptive medication you purchased from a pharmacy, only the injection is payable.
  - Genetic Testing

    We pay for BRCA (counseling about genetic testing) – for women at higher risk

We do not pay for:

- Screening services other than the ones listed above.

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Private Duty Nursing Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for private duty nursing services in your home or in a hospital subject to the conditions described below:

We pay for:

Skilled care given by a private duty nurse if:

- The patient's medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient

Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to us for services. **All progress notes must be submitted with the claim form.** We will pay the approved amount to you.

We do not pay for:

- Custodial care

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Professional Services

The services in this section are in addition to all other services listed in this certificate that are payable to a professional provider.

- Certified Nurse Practitioner Services: We pay for covered services provided by a certified nurse practitioner.

- Inpatient and Outpatient Consultations: We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

  We do not pay for staff consultations required by a facility's or program's rules.

Consultations in an in-network physician's office are subject to copayment requirements.

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Prosthetic and Orthotic Devices

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For durable medical equipment services, see Page 34.

Locations: We pay for prosthetic and orthotic devices while you are in a participating hospital or for use outside of the hospital subject to the conditions described below.

We pay for:

Prosthetic and orthotic devices prescribed by a physician or certified nurse practitioner and permanently implanted in the body or those used externally as part of regular hospital equipment. The prescription must include a description of the equipment and the reason for the need or the diagnosis. Covered services include:

- The cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features
- Repairs, limited to the cost of a new device

For purposes of ocular prostheses only, the definition of physician includes an optometrist who is also a prosthetist.

The replacement of a prosthetic device is payable if necessary due to:

- A change in the patient's condition
- Damage to the device so that it cannot be restored
- Loss of the device

Coverage Guidelines

BCBSM covers external prosthetic and orthotic devices that are generally considered payable by Medicare Part B as of the date of purchase or rental. In some instances however BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

To be covered, custom-made devices must be furnished by a provider that is fully accredited, or with BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc (ABC). You may call us to confirm a provider's status.

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Prosthetic and Orthotic Devices (continued)

Coverage Guidelines (continued)

Prosthetic and orthotic suppliers may include M.D.s, D.O.s, podiatrists, prosthetists and orthotists who meet BCBSM qualification standards.

Provider Limitations

If a provider is participating with BCBSM but is not accredited by ABC, only the following devices are covered:

- External breast prostheses following a mastectomy. These include:
  - Two post-surgical brassieres and
  - Two brassieres in any 12-month period thereafter

  Additional brassieres are covered if they are required because of significant change in body weight or for hygienic reasons
- Prefabricated custom-fitted orthotic devices
- Artificial eyes, ears, noses and larynxes
- Ostomy sets and accessories, catheterization equipment and urinary sets
- Prescription lenses (eyeglasses or contacts) following cataract surgery for any disease of the eye or to replace a missing organic lens. Optometrists may provide these devices.
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses (as defined in Section 7) when approved. Dentists may provide these devices.
- Some prefabricated items, such as wrist braces, ankle braces, or shoulder immobilizers, are payable when provided by an M.D., D.O., or podiatrist because the patient has an urgent need for the devices. Please call your local customer service center for information on which devices are covered.

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Prosthetic and Orthotic Devices (continued)

We do not pay for:

- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets.
- Hearing aids
- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hair pieces, hair implants, etc.

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Provider-Delivered Care Management

See Section 2 beginning on Page X for what you may be required to pay for these services.
See Section 7 for the definition of Provider-Delivered Care Management (PDCM).

Provider-delivered care management services are covered only when performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out of state. A care manager is a trained clinician, such as a registered nurse, clinical licensed master's of social worker, certified nurse practitioner or physician assistant. This section describes what we cover for all provider-delivered care management services.

Locations: We pay for professional services for provider-delivered care management in the following locations, subject to the conditions described below:

- A professional provider's office
- An outpatient hospital or participating facility
- A patient's home
- Other locations as designated by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out of state

We pay for:

Care management services identified by BCBSM that providers render to BCBSM members, only when performed by:

- In-network BCBSM-designated providers in Michigan, or
- Out-of-state providers who are designated by their local Blue Cross/Blue Shield plan to render care management services.

Deductibles, copayments and coinsurances (if any) are not required for these in-network services. Out-of-network services are not covered.

Provider-delivered care management services may include:

- Telephonic, individual face-to-face, and group interventions
- Medication assessments to clarify the appropriateness of the drug, the correct dosage to take, when to take it and to identify potential conflicts
- Care transitions after a hospital discharge to ensure an understanding of discharge instructions and the member's follow-up with his or her primary care physician
- Action plans that help the member better manage his or her health and set goals for improvement

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Provider-Delivered Care Management Services (continued)

Goal-setting and self-management support is included in most PDCM services. In-person contact will be encouraged between members and their care managers, whenever possible. Services are subject to change.

Eligibility

You are eligible to receive PDCM services if you have:

- Active BCBSM coverage
- One or more conditions that indicate that care management services have the potential to improve well-being
- Agreed to actively participate with PDCM
- A referral for care management services from your physician

  Your physician will determine your eligibility and refer you for care management services based on factors, such as your:

  - Diagnosis
  - Admission status
  - Clinical status

Termination of Provider-Delivered Care Management

You may opt-out of PDCM at any time. BCBSM may also terminate PDCM services based on your nonparticipation in PDCM, cancellation of your BCBSM coverage, or other factors.

We do not pay for:

- Services rendered by providers not designated for provider-delivered care management

For more information on Provider-Delivered Care Management services, you may contact BCBSM customer service.

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Radiology Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For radiology services in an ambulatory surgical facility, see Page 95.

Locations: We pay for hospital, facility and physician diagnostic and therapeutic radiology services in:

- A participating hospital, inpatient or outpatient, or participating outpatient facility
- A BCBSM-approved physician's office

We pay for:

Diagnostic Radiology Services

- We pay for facility and physician diagnostic radiology services to diagnose disease, illness, pregnancy or injury. The services must be provided by your physician or by another physician if prescribed by your physician:
  - X-rays
  - Radioactive isotope studies and use of radium
  - Ultrasound
  - Computerized axial tomography (CAT) scans
  - Magnetic resonance imaging (MRI)
  - Positron emission tomography (PET) scans
  - Medically necessary mammography
- Restrictions
  - Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities. Also you may call us for information about any restrictions.

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Radiology Services (continued)

Diagnostic Radiology Services (continued)

Restrictions (continued)

- Select radiology procedures, such as CAT, MRI and PET scans are payable **if**:

  - The provider requests preapproval. However, preapproval is not required for radiology procedures:

    - Performed out-of-state
    - Performed in cases of emergency
    - Payable through Medicare because it is your primary coverage

  - The procedures for which preapproval was requested fall within BCBSM medical policy guidelines and
  - We approve the procedures
  - The procedures are performed in a participating facility. (You or your physician may call us about the status of a specific facility.)

  If any of these requirements are not met, BCBSM will **not** pay for the procedure. You will not be responsible for paying the provider for a procedure that has not been preapproved.

  You may call us for information about any restrictions.

We do not pay for:

Procedures not directly related and necessary to diagnose a disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

Therapeutic Radiology Services

We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by your physician or by another physician if prescribed by your physician.

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Skilled Nursing Facility Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for facility and professional services in a skilled nursing facility.

Requirements:

We pay for an admission to a skilled nursing facility when:

- The skilled nursing facility **participates** with BCBSM
- The admission is ordered by the patient's attending physician

We require written confirmation of the need for **skilled care** from the patient's attending physician.

Length of Stay

We pay only for the period that is necessary for the proper care and treatment of the patient up to a maximum of 120 days per member, per calendar year.

We pay for:

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or purchased from the skilled nursing facility

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Skilled Nursing Facility Services (continued)

We pay for: (continued)

- Physician services (up to two visits per week)
- Physical therapy (Page 66), speech and language pathology services (Page 88) or occupational therapy (Page 53) when medically necessary

The physical therapy, occupational therapy or speech-language pathology services performed in a skilled nursing facility are considered inpatient benefits. Only when these services are provided in any outpatient location does the 60-visit benefit maximum apply.

We do not pay for:

- Custodial care
- Care for senility or developmental disability
- Care for substance abuse
- Care for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)
- Care provided by a nonparticipating skilled nursing facility

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